

“Enrollment in 2014: What’s at Stake for States?”
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HIT Policy Committee Enrollment Workgroup
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Good afternoon. My name is Alice Weiss and I am the Deputy Director of the Maximizing Enrollment for Kids Program at the National Academy for State Health Policy (NASHP), a non-profit, non-partisan organization dedicated to improving state health policy and practice. Thank you for the opportunity to speak with you today about your work to develop protocols and standards for implementation of simplified and streamlined eligibility provisions under the Accountable Care Act.

Maximizing Enrollment for Kids is a four-year, \$15 million initiative funded by the Robert Wood Johnson Foundation that aims to help states increase enrollment and retention of eligible children in Medicaid and CHIP, document what works, and share lessons with other states. Drawing from our work with the 8 leading states participating in Maximizing Enrollment for Kids and NASHP’s other work, I will provide a perspective on where states are today, where states should be going in years ahead, and opportunities we see for your workgroup to help them get there. My testimony today will draw heavily from a recent report we released that summarized findings from our assessment of our 8 grantee states’ enrollment and retention systems.¹ I also offer the report for the workgroup’s consideration as part of the record of this meeting.

Where Are State Enrollment and Retention Systems Today?

Today, states find themselves at a critical crossroads in their efforts to streamline and simplify eligibility and enrollment. Many states have made and continue to make significant progress in their simplification efforts, and in a number of leading states streamlined enrollment in Medicaid and CHIP is setting the standard by which new enrollment systems will be judged. However, streamlined enrollment systems and procedures are still not widespread among Medicaid and CHIP programs, and even among the leading states very few if any appear to meet all of ACA’s high standards for enrollment and interoperability that your workgroup is charged with creating. In thinking about where states are today, it is worth noting four key observations.

First, implementing the breadth and scope of simplification standards contemplated in ACA will require substantial change for most states. ACA mandates your workgroup to develop protocols and standards under which states would be able to match Federal and state data electronically to determine eligibility, accept documents and verify eligibility electronically, use existing data to renew coverage, and allow individuals to manage their benefits and eligibility information online at home, points of service or other community-

¹ Edwards, Jennifer et al., *Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States*, (Portland, ME: National Academy for State Health Policy/Robert Wood Johnson Foundation, February 2010).

based organizations. While we lack complete data for adult populations on the number of states that have implemented these types of strategies, data from our recent survey of CHIP programs and what we are learning from our work with leading states in Maximizing Enrollment for Kids suggests most states will have to make substantial changes to be compliant with new streamlined enrollment standards.

CHIP programs are newer, smaller, nimbler, and more likely to have adopted simplification strategies, but even among CHIP programs just about half or less of the states have adopted any one of these simplification strategies at this point. NASHP surveyed state CHIP programs last year and will be releasing the findings in a new Charting CHIP report very soon. According to our unpublished CHIP survey data (including responses from 46 of the 51 CHIP programs (including separate CHIP and Medicaid expansion programs)):

- Online applications can now be submitted in at least half the CHIP programs (17 separate CHIP and 8 Medicaid expansion); of these four states allow applicants to get a preliminary determination of eligibility online;
- Saving and storing eligibility information online by applicants can be done in at least 12 CHIP programs (9 separate CHIP and 3 Medicaid expansion);
- Third-party data matching to verify income eligibility is used in at least 13 CHIP programs (data only collected from separate CHIP programs); and
- Applicants can submit documents electronically in at least 4 CHIP programs (3 separate CHIP and 1 Medicaid expansion).²

Among the 8 leading states we are working with in the Maximizing Enrollment for Kids program, we see broader adoption and have more detailed information about innovations, but the adoption of streamlined enrollment strategies required under ACA are still not universal. Among Maximizing Enrollment for Kids states:

- Online applications are available in all but one state, but applicants can use electronic signatures to submit their application electronically in only half the states;
- Using existing data sources for renewal, either with pre-populated renewal forms (6 states) or ex parte renewal using SNAP, tax, or other income information (1 state) is happening in all but one state;
- Vital records checks are being used for citizenship verification in all but one state and other third-party data matching for enrollment is being used in at least half the states;
- A single client identifier is used to share eligibility data across Medicaid and CHIP in 5 of the 8 states;
- Electronic case records are being used in at least three states, with more planning to implement in coming years;
- Express Lane Eligibility (ELE) is being used to auto-enroll children in one state and being implemented for identification and possible enrollment in another;

² Hess et al., “*Charting CHIP IV: An Analysis of the Fourth Comprehensive Survey of State Children’s Health Insurance Programs*,” (Portland, ME: National Academy for State Health Policy, (forthcoming)).

- Application kiosks where individuals can apply remotely, in a rural local health department, community health center, emergency room or other public place like a library or post office, are being used in one state and considered in another; and
- Online renewal is being planned in half the states.³

One notable exception in states' relatively low rate of adoption of electronic tools for enrollment and retention is the new Social Security Administration State Verification and Exchange System (SVES) option to verify identity and citizenship electronically created under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). At least 28 states (Medicaid and CHIP programs) are either using or testing this electronic data exchange and preliminary experience has been very positive, with states experiencing the new strategy as simple to start up, easy to use, providing some administrative savings and lowering the burden on applicants. The Social Security Administration reports an average positive match rate for submissions of approximately 94 percent of applicants submitted.⁴ Apart from this exception, most state Medicaid and CHIP programs will have to make substantial changes to ensure they are ready for the new simplification standards that will be expected of them in 2014.

Second, to quote the indomitable Ruth Kennedy, "simplification isn't simple". Change, even small change, requires a lot of work, time, and staff resources. States often need legislative or regulatory action before they can begin to implement procedural change. Even once they enact or regulate a policy changes, there are often bureaucratic hurdles and challenges that can slow down the process of implementation. In many cases, the CHIP and Medicaid agencies are not in the same agency, or are separate from the agency responsible for eligibility determinations (often the welfare agency), making the implementation process difficult to coordinate. Eligibility determination agencies often have their own priorities related to the other social programs they administer and the priority to simplify health program enrollment does not always jibe well with the agency interest in taking a harmonized approach to all programs or rank as a priority against other priorities like minimizing fraud. The implementation process can also be complicated by political opposition related to concerns about costs or fraud, or from the time-intensive need to include stakeholders or the legislature. For example, one state worked with outside stakeholders on small but important changes to their application form for nearly two years. While the resulting application was better, it took so long to implement that it will quickly be displaced by a new online version of the application.

Local control creates challenges for states and can undermine efforts to implement change quickly and consistently. Local agencies, either counties or municipalities, often lack the resources needed to invest in change, or their resources vary widely. In some cases, local agencies are controlled by counties or municipalities and do not share the

³ Edwards, Jennifer et al., *Maximizing Enrollment for Kids: Results from a Diagnostic Assessment of Enrollment and Retention in Eight States*.

⁴ Ross, Donna Cohen, *New Citizenship Documentation Option for Medicaid and CHIP is Up and Running: Data Matches with Social Security Administration Are Easing Burdens on Families and States*, (Washington, DC: Center on Budget and Policy Priorities, April 20, 2010).

priorities of the state government seeking to implement simplifications. In other cases, the local office workers are employed by the state but implementing the change across many offices throughout the state can be resource intensive and it can be difficult for the state to monitor implementation to ensure accountability. In either case, local control can create new wrinkles in state efforts to promote interoperability among programs.

Third, and perhaps most significantly, state eligibility systems are often antiquated, unable to talk to other eligibility systems, require expensive and complex “work-arounds” to adapt, and would require a significant investment of staff time and resources to upgrade. Our diagnostic assessment of state enrollment and retention systems cited the use of a single identifier across programs and a single or compatible information system across programs as two key successful strategies that were aiding state efforts to enroll and retain children. Conversely, our assessment found that reliance on Medicaid legacy systems presented significant challenges to state efforts to maximize enrollment and use data to monitor efforts. Among Maximizing Enrollment for Kids states, about five of the states use a single identifier and about half of the states use a single or compatible information system across sites.

Most state Medicaid eligibility systems are outdated and upgrading them will be costly. While some systems have been updated, some are much older, in some cases as much as three decades old. States will either have to pay for upgrades or completely revamp their systems to build the type of interoperability expected under ACA’s new standards, which could cost hundreds of millions of dollars in the worst cases. Even states with newer systems will likely need to create workarounds to make them operable for health reform implementation given the magnitude of change contemplated.

To put it simply, the types of eligibility system changes being required by ACA are vast and deep and states’ current eligibility systems are not prepared to handle them. Many state systems do not now routinely exchange data, but ACA will require continuous transfer of eligibility data not just between Medicaid and CHIP, but also with the Exchange. Today, in many states only the Medicaid agency can determine eligibility. By contrast, ACA will require Exchanges to screen and enroll for Medicaid eligibility and states to accept the Exchange’s determination, a change that will require setting up new rules for Medicaid determinations by an outside entity and require the eligibility systems to accept eligibility determinations from outside entities. Today, Medicaid agencies have complex rules for documentation of income, resources, assets and income disregards. In a post-reform world they will have to create an entirely new eligibility system to provide parallel eligibility determinations for most adults, children and pregnant women under the new modified adjusted gross income (MAGI) rules, while other populations are still subject to the old eligibility rules. In addition, for change, states will need to retrain programmers, analysts, and caseworkers on the new rules, which is costly and time-consuming. Any one of these changes would be enough to prompt a system overhaul, but the combined effect of these changes creates a perfect storm that could overwhelm states without significant additional resources to help states plan for and fund the changes needed.

The challenges states face in updating their eligibility systems are exacerbated by the absence of focused federal financing and policy support for change under current law. Today, state Medicaid claims data systems are funded at a 90 percent federal match rate for creation and a 75 percent federal match rate for maintenance. The American Recovery and Reinvestment Act (ARRA) Health Information Technology for Economic and Clinical Health (HITECH) Act provisions created new significant investments in state and private efforts to collect and organize electronic health record data for clinical oversight and quality improvement efforts, allowing states to claim for “meaningful use.” By contrast, eligibility data systems are not subject to more favorable federal financing or special grants under current law. States that seek to improve eligibility systems can only claim a 50 percent federal match through Medicaid’s administrative services matching rate. And, although ACA provides an opportunity for the Secretary to provide new grants to states to develop new or adapt existing technology systems in light of these new standards, the bill failed to identify or appropriate a specific amount of funds, leaving states uncertain as to whether the funding provided will be sufficient.

Finally, while it has been mentioned already, state resource limitations cannot be overstated in any conversation about policy change. States are experiencing some of the worst budget crises on record and are facing hiring freezes, mandated furloughs, pay freezes and an aging workforce that will be retiring with few ready experienced replacements. Even in Medicaid and CHIP agencies where programs have been relatively protected, the ripple effect of staffing shortages and the difficulty of working with other agencies strapped for resources have created an environment where many state agencies feel stretched thin. While states continue to press forward in their simplification efforts, many states feel they lack the staff, expertise, vision and financial support they need to make the dramatic changes contemplated here.

What Should the Future Look Like for State Enrollment and Retention Systems?

The future of state enrollment and retention systems must include streamlined enrollment in a modernized interoperable system that promotes interagency coordination and is seamless to individuals and families. First and foremost, enrollment must be easy, accessible, rapid, and include real-time functionality that allows state systems to pull data from multiple sources to expedite eligibility determinations while minimizing the burden of documentation for individuals. The principle of government agencies working together to minimize documentation burdens for citizens should apply. In a rules-based environment, where documents can be scanned, stored and used for multiple applications, a pay stub documenting income for Medicaid should be accessible to the Exchange entity as well. Individuals should be able to “sign” applications and submit online or over the phone (as they can do in a few states now).

Accessibility means applications are available in multiple formats, including paper, telephone, and online, and multiple sites, including urban and rural areas, at community-based organizations or provider offices. Applications should also be available in multiple languages and translation services should be available for rare languages and to answer questions. And while technology can improve accessibility, we cannot overlook the

value of the human touch in improving enrollment. Early anecdotal experience with online enrollment among some of the Maximizing Enrollment for Kids states suggests that while a significant population is ready to embrace new technologies like online applications, individuals submitting applications online may be at greater risk of making mistakes in the application process that can delay their application from being approved. Even the best technologies cannot replace the importance of individuals having personal assistance in applying and navigating the process, and whatever assistance is provided must accommodate the varying needs of the beneficiary community including translation services for limited English proficient groups and accommodating special needs and disabled populations.

In a modernized interoperable system, eligibility systems could talk to each other without the need for additional steps to allow for eligibility data to flow from one system to another to verify eligibility. States and federal agencies would be able to work together to promote secure information connections that allow eligibility data to flow freely without a risk of private information being inadvertently shared publicly or running afoul of state or federal privacy laws. State agencies could work together within a unified data system that included a single client identifier for tracking individuals across programs. State eligibility system improvements would be supported both through substantial federal financing for development and upgrades and the availability of either a uniform platform or open source technology for states to use so Medicaid wouldn't waste millions of taxpayer dollars on recreating different eligibility systems in 51 jurisdictions. And a modernized system would enable states to integrate eligibility systems for programs horizontally including Medicaid and CHIP, Exchange coverage, and social programs (e.g., Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Programs (SNAP), free and reduced school lunch program, Low-Income Heat Energy Assistance Program (LIHEAP), etc.). There is no reason why the rising tide of streamlined enrollment for health coverage should not lift all boats to improve enrollment of eligible low-income citizens into all of these programs.

Future enrollment systems should also be seamless to the individual applying. Individuals should be able to apply at any agency and have the application considered and determined with minimal processing. Individuals who become eligible for another program should be automatically transferred and enrolled with little or no additional documentation. States should to the greatest extent possible rely on existing data to renew eligibility. Seamless enrollment should also ensure that the process for families to apply and enroll in coverage is simple and manageable, regardless of the type of coverage or the citizenship status of the eligible individuals. The challenges of managing families with mixed coverage eligibility and immigration status will be significant, but these must be overcome to ensure the new system is delivering its promise of improved access to all.

How Can This Workgroup Accelerate the Progress Toward These Goals?

This workgroup has an opportunity to move our nation's eligibility system forward toward this lofty vision in at least four concrete ways: by promoting methods for states to easily adopt new system protocols; by bringing states together and hearing their concerns

directly; by encouraging changes that build on existing programs; and by providing support for appropriate and timely funding and other resources to help states implement the protocols the Secretary adopts. I will discuss each of these in turn.

First, this panel should recommend and promote methods for states to easily adapt their eligibility systems to conform to new requirements and promote interoperability. To accomplish this goal, the panel could consider recommending the federal government pursue a number of options, including building a prototype system that could be shared and adapted by states, developing a new system platform with minimum requirements that would be available through open source technology, or contracting exclusively with a limited number of technology contractors to provide states with more defined paradigms as to what is needed to meet new federal requirements. Although states have historically sought flexibility in implementation of health programs, as they confront the need for so much change quickly coupled with uncertainty about design needs, they are increasingly calling for uniformity and would likely embrace more of a one-size-fits all approach to minimize confusion and expense. However, any system that is built for states must meet a number of important specifications. It must allow for streamlined data sharing with states in the new MAGI environment which means exchange between state agencies and the Treasury Department or its proxy for annual tax data. It must address challenges in how to handle changes in circumstances during the year and help programs assimilate the gulf between a monthly eligibility program like Medicaid and annual tax data upon which eligibility will be derived. In addition, whatever system-building option is chosen, states will need a lot of lead time to plan, procure, implement and train workers to use the new system, so the need for guidance and action in this area is imperative.

Second, this panel should seek opportunities to include states directly in the development and implementation of protocols. Having representation on the workgroup by a number of current and former state officials is a great start, but there is no substitute for having a more direct conversation with the states that will be implementing these requirements. Soliciting feedback on top state priorities for these standards should be a component of the workgroup's agenda, including addressing barriers states may perceive in implementing reform. In addition, the panel should recommend that states be convened to discuss the Secretary's protocols and standards once they are finalized. This panel should also recommend the Secretary pursue opportunities for the federal government to bring state officials together to discuss challenges in implementation and work through ideas and solutions.

Third, the workgroup should promote changes that build on existing structures that are working. If we have learned nothing from our experience with implementation of CHIP more than a decade ago, it is that developing a new program that is separate from existing agency structures can create significant procedural challenges to integration. Although there have been many benefits from CHIP's relative independence as a program, one significant drawback has been the extent to which it has created new silos of coverage and program management. Any new eligibility systems in a post-reform world should, to the greatest extent possible, build on existing systems that work and work to promote integration. This workgroup could greatly aid this effort by recognizing and affirming

that states do not need to and in many cases should not establish a separate exchange outside of existing Medicaid and CHIP programs and should instead work to create a more integrated system overall. Silos are expensive, burdensome, inefficient and have no place in a modernized eligibility system. Your workgroup would do a great service to the future health care system by exhorting states and the federal government to operate under the principle: first, build no silos.

Finally, as discussed above, states need substantial resources to implement the dramatic changes being contemplated. The most urgent priority is ensuring states have access to funding to support these goals, either through the grants outlined in ACA or through a legislative or regulatory interpretation that allows them access to a more generous federal match rate for eligibility system improvements in Medicaid and CHIP. Although funding is key, it is not the whole picture. States need technical expertise, which could be provided at the federal level through technical assistance providers. They need more assistance in planning for change. And they need the opportunity to learn about federal requirements, opportunities and best practices. This workgroup's recommendations should acknowledge and support these needs.

In conclusion, I want to thank the workgroup for the invitation to share NASHP's thoughts with you today. The charge for this workgroup's contribution to health reform implementation is challenging, but also critically important to states' success in ensuring the promise of improved access to health coverage for all Americans. We look forward to working with you in your efforts to advance these goals and stand ready to assist your efforts. Thank you.